



Robert L. Ehrlich, Jr., Governor  
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## Electronic Newsletter

### Fall 2005

The Perinatal Network News is a publication of the Department of Health and Mental Hygiene's (DHMH) Center for Maternal and Child Health (CMCH.) It is funded through a Crenshaw Perinatal Health Initiative grant provided to the Montgomery County Health Department.

The publication is intended as a communication tool for sharing perinatal information for a statewide audience, with information and resources that address statewide issues. It is designed as a vehicle to encourage collaboration and networking throughout the state. The newsletter provides an opportunity to share information on preconception and perinatal health issues and priorities, infant morbidity and mortality, county statistical trends and perinatal and child health indicators. It is an opportunity for local programs to share their strengths and insights as well as opportunities to ask for feedback and assistance in solving a local problem.

To ensure that this newsletter is a success, we need and encourage your participation. Please let us know of any items you would like to contribute, if you have suggestions for topics or areas you would like to see covered, or if you see that incorrect information was provided or that important information was inadvertently left out.

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# Perinatal network

Maryland Department of Health and Mental Hygiene

## Answering the "Call for Action" in the Prevention, Diagnosis and Treatment of Prenatal Alcohol Related Disability in Maryland

*Paula J. Lockhart, MD, Assistant Professor of Psychiatry, the Kennedy Krieger Institute*

Over 30 years ago researchers identified an irreversible but preventable developmental disability in infants born to women who drank heavily throughout pregnancy. This condition was called Fetal Alcohol Syndrome (FAS.) Although there are many physical anomalies associated with this condition, essential characteristics required for diagnosis included: 1) Pre- and postnatal growth retardation; 2) Dysmorphic facial features (flattened philtrum, thin upper lip and short palpebral fissures); 3) Central nervous system impairment; and 4) prenatal alcohol exposure. Subsequent studies on the central nervous system determined that only one alcoholic drink during pregnancy can lead to selective brain changes, depending on timing, amount, and concentration of the alcoholic beverage. Effects in the offspring are however varied.

Each exposed child's strengths and areas of impairment are based on numerous factors. This multifactorial vulnerability is not only based on how much and when the alcohol exposure occurred but also may include problems arising from other prescription or illicit drugs consumed, the nutritional status of the mother, her age, general health status, whether or not she is a binge or daily drinker, and also on issues such as multigenerational psychiatric history, quality of the environment, and the presence of abuse and neglect in the child's life. Fortunately, some exposed individuals have biological factors which are protective, reducing the effect of alcohol's deleterious effects on the central nervous system. This effect has led some doctors and other health professionals to minimize the dangers of drinking during pregnancy. Hundreds of research articles do not support this minimization. It can occur in any individual who is exposed to alcohol during pregnancy. Additionally, this condition is not confined to any specific ethnic group or socioeconomic level.

To answer the question of whether prenatal alcohol exposure alone is responsible for the FAS phenotype, researchers have created the FAS facial characteristics and central nervous system impairment in laboratory animals. Alcohol alone is found to be a potent neurotoxin. To make the argument more convincing, there are examples of women who drank during one pregnancy but stopped in subsequent pregnancies. The unaffected younger offspring have been known to take care of their older disabled sibling. Complicating matters further, parents complain that the identifying criteria necessary to be diagnosed as having an alcohol related disability is too narrow. They observe that children who do not have the characteristic physical features necessary for a FAS diagnosis, but have known alcohol exposure, still have disability that is often as severe or at times more severe than individuals with FAS. Most of these individuals have average intelligence, are chatty, sometimes robust and attractive, but by virtue of the effects of

alcohol on the developing brain have serious cognitive impairment affecting their ability to learn and function normally. Among other problems these individuals can be socially inappropriate, demonstrate intermittent memory lapses for important facts like their address, do not necessarily learn from their mistakes, are taken advantage of by others, have poor judgment, have difficulties understanding cause and effect and have trouble with transitions. Individuals with this disability, that have no outward physical signs, are generally unidentified and under-treated in our community. This condition is called Alcohol Related Neurodevelopmental Disorder (ARND.) The spectrum of alcohol's damaging effects from FAS to ARND (from mild to severe) is called Fetal Alcohol Spectrum Disorders.

Babies with Fetal Alcohol Syndrome are generally born small for gestational age in height and weight, may have regulatory problems, and also breathing, sleeping or feeding problems (i.e., failure to thrive). Individuals with alcohol related disability without FAS (ARND) may often suffer from isolated cognitive and behavioral problems but not enough to signal this condition early on. Parents may find later that their child has inattention, hyperactivity or restlessness, impulsivity, problems in social cognition, aggression and outbursts ("melt downs"). Sensory processing problems can be a major problem for the child in that they may be over-stimulated by sensory input (touch, light, sound, etc.) causing some of the temper outbursts. The child who is affected that has average intelligence may be considered lazy and resistant, instead of brain damaged, by their parents and teachers.

The tragedy facing our society is that women are still being advised by their doctor that a glass of wine from time to time is not going to cause problems in their unborn child. The research shows, however, that alcohol selectively kills neurons in different regions of the developing brain. Since the central nervous system is developing throughout pregnancy

and the brain remains vulnerable to damage, it has been demonstrated scientifically and logically that there is never a safe time to drink. It is unknown how many individuals have been exposed to alcohol prenatally and have a good outcome. But we do have an idea of the unlucky individuals that suffer profound disability.

Fortunately, through the advocacy of a number of parents, parent groups, and pioneering government officials, the understanding of this disorder has transitioned out of the research laboratories, and started reaching into the communities, where as many as one in one hundred affected individuals and their families live. There are a number of federal agencies that have devoted tremendous financial support to the cause of FASD including the National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute on Child Health and Human Development (NICHD), Centers for Disease Control (CDC) and Substance Abuse and Mental Hygiene Services Administration (SAMHSA) (FASD Center of Excellence.) There are also a number of US states that have stepped up to the plate and put resources in place to plan and implement effective services, and to practice prevention through education of women. Maryland is now joining this proactive group of states with Governor Ehrlich calling for a workgroup on Fetal Alcohol Spectrum Disorders. Delegate Pauline H. Menes and the Special Committee on Drug and Alcohol have vehemently championed this issue and supported the passage of a FASD Public Awareness Campaign in Maryland.

Bonnie Birkel, Director of the DHMH Center for Maternal and Child Health, has been the chairman of what is now called "The Maryland State FASD Coalition." The group has grown to include state officials, parents and other interested individuals from the community. The main focus of the FASD Coalition is to carry out the FASD Public Awareness Campaign bill that was passed last year, and to plan "Maryland's call for action." The group's long term plan is to organize prevention efforts, increase health

service, improve education on FASD to human services workers on all levels, and generally elevate the care received by individuals and families affected by prenatal alcohol exposure. Educating clinicians of all disciplines about this condition, improving and increasing services, helping to prevent more individuals being born with alcohol related disability, will decrease human suffering. The well being of frustrated, overwhelmed families with an affected individual or individuals will improve. And because the occurrence of secondary disabilities in these individuals is so common—leading to confinement and dependence—it will elevate the community of Maryland.

In conclusion, we now recognize that FASD is an international public health problem involving every country whose child-bearing citizens consume alcohol. Although the outcome of the child is based on numerous factors, it has been shown without a doubt that prenatal alcohol exposure is a potent central nervous system toxin. An international team of researchers are assessing affected individuals in a number of countries, including the US, to survey the extent of the problem worldwide.

We have a lot of work to do in the State of Maryland to spread the word to all child-bearing women to not drink if they think they might become pregnant. If they are pregnant, it is strongly recommended to stop drinking immediately. Continuing to take that glass of wine to relax during pregnancy is like playing Russian roulette with the unborn child. The advice from FASD researchers is to treat alcohol like any other toxic substance you wouldn't consume during pregnancy. This warning includes beer, wine, wine coolers, liquor, mixed drinks and cordials. We of the Maryland FASD Coalition envision a time when all women understand the dangers of drinking during pregnancy, all health care professions are educated about the causes and effects of prenatal alcohol exposure, and every person and family affected by prenatal alcohol related disability has an opportunity for a happy and healthy future. Again,

early intervention is the key to a better tomorrow for these individuals. We applaud the efforts of Governor Ehrlich, Delegate Pauline Menes, and the Special Committee on Drugs and Alcohol for their part in supporting this very important public health issue.

The SAMHSA sponsored FASD Center of Excellence is supporting the development of a FASD Diagnostic and Treatment Center at the Kennedy Krieger Institute with affiliated diagnostic centers located throughout Maryland. The estimated date of completion of this center is summer, 2006. In the meantime, children suspected of suffering from prenatal alcohol related disability should be referred to their pediatrician, developmental pediatrician, or pediatric neurologist and follow up with a neuropsychological evaluation and possibly a speech and language and occupational therapy evaluation if appropriate.

If you are interested in joining the Maryland State FASD Coalition, contact Bonnie Birkel at [birkelb@dhmh.state.md.us](mailto:birkelb@dhmh.state.md.us).

### Resources:

The Surgeon General's Advisory on Alcohol Use during pregnancy (February 2005) is available at:

<http://www.surgeongeneral.gov/pressreleases/sg02222005.html>

National Organization on Fetal Alcohol Syndrome

[www.nofas.org](http://www.nofas.org)

DHHS Substance Abuse and Mental Health Services Administration (SAMHSA) clearinghouse

[www.ncadi.samhsa.gov/](http://www.ncadi.samhsa.gov/)

SAMHSA FASD Center for Excellence

<http://www.fascenter.samhsa.gov>

National Center for Birth Defects and Developmental Disabilities

[www.cdc.gov/ncbddd](http://www.cdc.gov/ncbddd)





# Breastfeeding During Emergencies: Resources for Health Care Providers

*Compiled by Lily Fountain, MS, CNM, University of Maryland School of Nursing*

Breastfed babies should continue breastfeeding after a natural disaster or power outage. For formula-fed infants, use ready-to-feed formula if possible. If using ready-to-feed formula is not possible, it is best to use bottled water to prepare powdered or concentrated formula. If bottled water is not available, use boiled water. Use treated water to prepare formula only if you do not have bottled or boiled water.

- ▲ If you prepare formula with boiled water, let the formula cool sufficiently before giving it to an infant.
- ▲ Clean feeding bottles and nipples with bottled, boiled, or treated water before each use.
- ▲ Wash your hands before preparing formula and before feeding an infant. You can use alcohol-based hand sanitizer for washing your hands if the water supply is limited.

According to La Leche League (an international organization dedicated to assisting mothers with breastfeeding information) nursing mothers may worry that stress will affect their milk supply. Stress does not necessarily prevent a mother from producing milk. Interventions to support breastfeeding mothers, and mitigate stress factors as far as possible, should be encouraged.

Human milk is 87 percent water. **Nursing mothers need to drink to satisfy their thirst**, plus take a little bit more. If a mother is giving birth in an emergency situation, she needs to nurse right away to prevent hemorrhage. She needs to nurse about every two-three hours or more frequently, to achieve a rich milk supply.

If a mother has just given birth within five days or so and finds herself in an emergency situation, she needs to learn the importance of breastfeeding frequently, every two-three hours, and more for comfort if baby needs that, to give her baby the health advantages of human milk. Even if the mother thought that she would be feeding her baby formula, she can begin breastfeeding and have a free, safe, and constant source of food for her baby.

After a mother has given birth, she will keep her milk supply, often for five-six months. Of course if the breast is not stimulated during the initial days after birth, by baby or expression, the milk supply dwindles to just drops per day. If she is still producing some drops per day, she often can relactate. The general rule for relactation is stimulating the breasts, with a baby nursing or expression every two hours, the breasts will start to produce about one ounce per day. By the end of a week, the mother will be producing seven ounces and by the end of a month most mothers are up to a full supply, unless a medical situation affects their milk production. In emergency situations, mothers need to learn that it is okay to put the baby to an almost empty breast for comfort nursing and to learn that they can relactate. During relactations, mothers decrease the formula or donated human milk that they are using by about an ounce a day as their own milk increases by about an ounce a day. They need to make sure baby is urinating enough each day as they may not be able to count wet diapers, since diapers may not be available.

Source: LaLeche League News Announceme



## Lactation During Emergencies Web Resources

Emergency Nutrition Network Online

<http://www.enonline.net/ife/index.html>

WHO guidelines on Relactation

[www.who.int/child-adolescent-health/New\\_Publications/NUTRITION/WHO\\_CHS\\_CAH\\_98\\_14.pdf](http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/WHO_CHS_CAH_98_14.pdf)

U.S. Breastfeeding Committee: Infant and Young Child Feeding in Emergencies

<http://www.usbreastfeeding.org/Issue-Papers/Emergency.pdf>

International Lactation Consultant Association: Position on Breastfeeding in Emergencies

<http://www.ilca.org/pubs/InfantFeeding-EmergPP.pdf>

La Leche League: Emergency Breastfeeding Resources

<http://www.lalecheleague.org/emergency.html>

Baby Transport in Emergency: Babywearing

[www.mamatoto.org/](http://www.mamatoto.org/)

World Alliance for Breastfeeding Action: Fact Sheet on Feeding Babies in Emergencies

<http://www.waba.org.my/pdf/Factsheet.pdf>

## Pregnancy and Childbirth During Emergencies: Resources for Health Care Providers

Natural Disaster Effects on Pregnant Women, Centers for Disease Control

<http://www.cdc.gov/ncbddd/hurricanes/women.htm>

Keep Food and Water Safe after a Natural Disaster or Power Outage: Feeding Infants and Young Children, Centers for Disease Control

<http://www.bt.cdc.gov/disasters/foodwater.asp>

Giving Birth in Place: A Guide to Emergency Preparedness in Childbirth, American College of Nurse-Midwives

<http://www.midwife.org/display.cfm?id=622>

# Are Babies of Working Mothers Entitled to Receive Their Mother's Milk?

Hanan Aboumatar, MD, MPH and Amy Kovar Resnik, MS, RD, CSP, LDN,  
Working Mothers' Workgroup, Maryland Breastfeeding Taskforce

As health advocates for women and children, most of us will answer the title question with a resounding "Yes". However, how much support are we providing to those colleagues of ours who intend to breastfeed and continue working? As maternal and child health professionals, are we doing enough to advocate for breastfeeding support in our own workplaces? There are excellent examples of breastfeeding support models that are effective, and can be implemented with minimal cost. So, how much do we know about such excellent models and how willing are we to implement them in our workplaces at a time when they are widely implemented in the corporate world with excellent results?

These are questions that all of us involved in the child and maternal health field should address. This is particularly true now since recent breastfeeding research indicates evidence documenting benefits, not only for babies but also for mothers, employers and the community at large. In fact, the American Academy of Pediatrics has released a new policy statement on Breastfeeding and the Use of Human Milk. This new statement incorporates newly available research demonstrating breastfeeding's diverse benefits (see table below.) The statement not only recommends human milk as the optimal nutrition for human babies, but also warns about the risks of all other artificial feeding preparations. In fact, it advises against supplementing with formula except when medically indicated. Yet when women return to work, many employers expect them to start giving formula to their babies with no reason except that the workplace is not prepared to support their endeavor to continue breastfeeding.

## Breastfeeding Benefits Spectrum

Child Benefits	Maternal Benefits	Community Benefits
Less infections	Less bleeding Postpartum	Annual Savings on health care costs—\$3.6 billion
Less obesity	Faster return to pre-pregnancy weight	Savings on formula cost for public agencies
Less diabetes I and II	Child spacing	Child spacing
Less asthma	Decreased risk of ovarian cancer	Healthier children
Less cancer (Lymphoma, Leukemia, Hodgkin's)	Decreased risk of breast cancer	Less absence from work
Lower post neonatal mortality	Possible reduction in hip fractures	Increased employee productivity
Better cognitive development	Possible reduction in Osteoporosis	Environmental benefits: less consumption of formula and its supplies

Here are some facts that can assist us as we advocate for breastfeeding support in the workplace:

### ✓ Breastfeeding support carries financial benefits to employers.

Breastfeeding support programs are being increasingly implemented in various workplaces. Some of those workplaces report a \$3 return on investment for each \$1 spent. Breastfeeding support leads to lower health care

costs, improved productivity, and decreased absenteeism. Breastfeeding carries proven short and long-term health benefits for both mothers and babies. Breastfed babies are less likely to develop ear infections, diarrhea, allergies, asthma, and pneumonia. Studies have estimated \$200 savings on health care costs during the first year of life of a breastfed baby. Medical prescription costs alone are cut by 50 percent. In addition, studies have shown improved workplace satisfaction, higher morale, and improved productivity among breastfeeding mothers. Also, breastfeeding mothers have lower rates of absenteeism from work compared to formula feeding mothers.

### ✓ Breastfeeding support demonstrates employers' citizenship and social responsibility.

The United States Department of Health and Human Services has a national plan for action to support breastfeeding that calls on employers to institute worksite programs and take action to support and promote breastfeeding among their employees as they return to work. Breastfeeding support identifies a socially responsible organization that cares for the health and well being of children, mothers, families, and the community at large. Breastfeeding support is an environmentally-friendly action, due to lower resource consumption and less waste compared to artificial feeding.

### ✓ It is not hard to support breastfeeding in the workplace.

Many small and big employers have done it already. To learn more, visit the Maryland State Breastfeeding Task Force website at [www.marylandbreastfeeding.org/mch/breastfeeding/employers.html](http://www.marylandbreastfeeding.org/mch/breastfeeding/employers.html)

# Maryland AIDS Administration Protocol for Responding to the Needs of HIV-positive Katrina Survivors

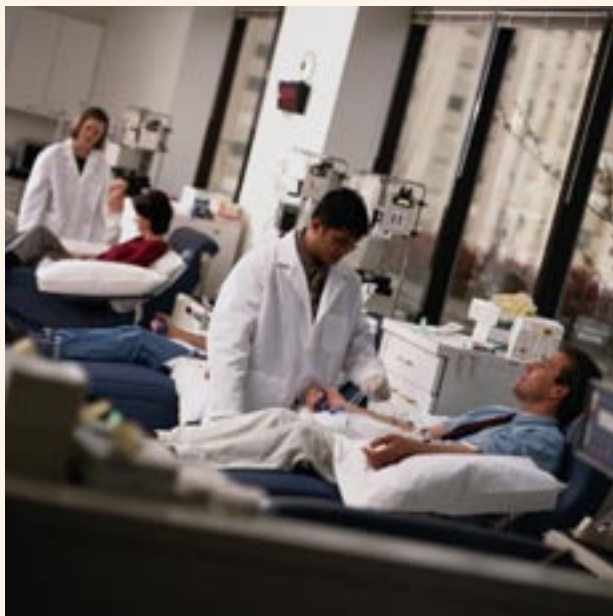
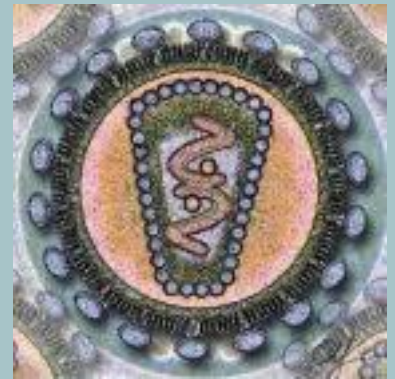
*Jessica Pollak Kahn, Chief, Center for HIV Health Services, DHMH-Maryland AIDS Administration*

The AIDS Administration has been working with other states and the National Association of State and Territorial AIDS Directors in response to the issues of HIV patients from the hurricane affected region who have been displaced all over the country

At this time, the AIDS Administration is asking that all local providers and health departments be aware of the potential for HIV patients being displaced into your community. The evacuees could potentially be without their HIV medications and/or be unclear about what medications they were taking before the hurricane. The evacuees may or may not approach health departments for continued care. Treatment delivery processes are different across the states. They may not be aware of whom to contact here, and may start by contacting indigent clinics or hospitals where they are used to finding HIV clinics in the south. Please share the information and heightened awareness with other providers in your community who may receive inquiries.

It is the goal of the AIDS Administration to insure that all HIV-infected evacuees who enter Maryland are able to continue their treatment and receive all needed medical attention. We are assuring services and then doing appropriate follow-up to continue services as needed through regular Ryan White services or private care.

For more information, or a copy of the Medicaid Program memo explaining the expedited approval process that was sent to all Medicaid providers and health departments, please contact Jessica Pollak Kahn for HIV services questions at: 410-767-5994 or [jpollak@dhmh.state.md.us](mailto:jpollak@dhmh.state.md.us). Please contact Linda Anders for MADAP/insurance questions: 410-767-5685 or [landers@dhmh.state.md.us](mailto:landers@dhmh.state.md.us)





# Clinical Presentation of Community-Acquired Methicillin-Resistant Staphylococcus aureus in Pregnancy

## Objective

The objective of this study conducted at the Department of Obstetrics and Gynecology, University of Texas Southwestern Medical Center at Dallas, Dallas, Texas, was to review the presentation and management of community-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) in pregnant women.

## Methods

This was a chart review of pregnant patients who were diagnosed with MRSA between January 1, 2000, and July 30, 2004. Data collected included demographic characteristics, clinical presentation, culture results, and pathogen susceptibilities. Patients' pregnancy outcomes were compared with the general obstetric population during the study period.

## Results

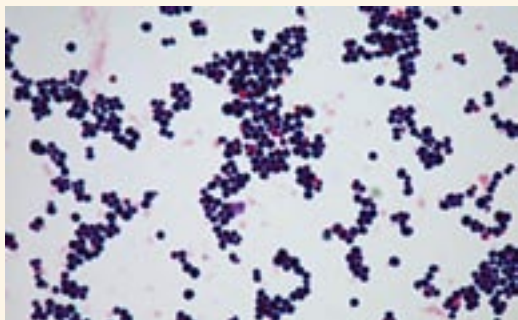
Fifty-seven charts were available for review. There were two cases in 2000, four in 2001, 11 in 2002, 23 in 2003, and 17 through July of 2004. Comorbid conditions included human immunodeficiency virus and acquired immunodeficiency syndrome (13%), asthma (11%), and diabetes (9%). Diagnostic culture was most commonly obtained in the second trimester (46%); however 18% of cases occurred in the postpartum period. Skin and soft tissue infections accounted for 96% of cases. The most common site for a lesion was the extremities (44%), followed by the buttocks (25%), and breast (mastitis) (23%). Fifty-eight percent of patients had recurrent episodes. Sixty-three percent of patients required inpatient treatment. All MRSA isolates were sensitive to trimethoprim-sulfamethoxazole, vancomycin, and rifampin. Other antibiotics to which the isolates were susceptible included gentamicin (98%) and levofloxacin (84%). In comparison with the general obstetric population, patients with MRSA were more likely to be multiparous and to have had a Caesarean delivery.

## Conclusion

Community-acquired MRSA is an emerging problem in our obstetric population. Most commonly, it presents as a skin or soft tissue infection that involves multiple sites. Recurrent skin abscesses during pregnancy should raise prompt investigation for MRSA.

Vanessa R. Laibl, MD, Jeanne S. Sheffield, MD, Scott Roberts, MD, Donald D. McIntire, PhD, Sylvia Trevino, MT and George D. Wendel, Jr, MD

*Obstetrics & Gynecology* 2005;106:461-465



## Task Force Recommends HIV Screening for All Pregnant Women

The U.S. Preventive Services Task Force has just issued a new recommendation calling for all pregnant women, not just those identified as at risk for contracting HIV, to be screened for the infection. The Task Force also reaffirmed its earlier recommendation that all adolescents and adults at increased risk for HIV infection be screened, and has broadened its definition of high-risk.

In addition to patients who report high-risk behaviors, all patients receiving care in high-risk settings such as homeless shelters or clinics dedicated to the treatment of sexually transmitted diseases should be tested.

The new recommendations are published in the July 5 issue of the *Annals of Internal Medicine*. [www.annals.org/current.shtml](http://www.annals.org/current.shtml)

The recommendations and materials for clinicians are also available on the Agency for Healthcare Research and Quality (AHRQ) Web site at

<http://www.ahrq.gov/clinic/uspstf/uspshivi.htm>

Previous Task Force recommendations and summaries of the evidence and related materials are available from the AHRQ Publications Clearinghouse by calling 1-800-358-9295 or sending an Email to [ahrqpubs@ahrq.gov](mailto:ahrqpubs@ahrq.gov).

Also, the AHRQ 800 number for their clearinghouse can be used to order (one per person) a copy of their summary of the task force findings on a variety of medical subjects.

## Prince George's County Pilots Model Prenatal Care Program

*Fran Preneta, M.P.H., Division of Maternal and Child Health, Maternal Health and Family Planning Program, Prince George's County Health Department*

As part of a broader infant mortality reduction initiative, the Prince George's County Health Department's Division of Maternal and Child Health has partnered with Prince George's Hospital Center OB/GYN Midwifery Associates to pilot test a model prenatal care program called CenteringPregnancy™. This program was created by Sharon Schindler Rising, MSN, CNM, FACNM, and piloted at the Waterbury Hospital in Connecticut in 1993–94. Since then, CenteringPregnancy has attracted the attention of many midwives, nurse practitioners and physicians who are now implementing the program in more than 20 sites throughout the United States and Canada.

CenteringPregnancy is a model of care provided in a group setting that combines the three major components of prenatal care—health assessment, education, and support. The group is comprised of 8-12 women with similar due dates who meet together for 10 90-minute sessions throughout their pregnancies and early postpartum period. The women join the group after receiving an initial nursing/medical assessment that includes a complete history and physical examination. The groups are facilitated by a trained group leader who is ideally a nurse-midwife or nurse practitioner. Typically, the first four sessions meet once a month and then increase in frequency to every two weeks for the last six sessions. In the group sessions, the women learn self-care skills, participate in facilitated discussions about their pregnancy experiences, and develop a social support network with other group members.

The benefits of CenteringPregnancy have been well documented and include strong satisfaction with the model by both participants and providers. In addition, the research findings on CenteringPregnancy indicate that there is a statistically significant reduction in emergency department visits among participants by the third trimester, a reduction in low birth weight in preterm infants born to women in the Centering groups, and cost effectiveness of delivering prenatal care in a group setting. For these reasons, the Health Department decided to implement a CenteringPregnancy Program on a trial basis in its Maternity and Family Planning Program, which sees approximately 1,000 new prenatal clients every year. The program is being funded by a grant from the March of Dimes.

The Health Department's first CenteringPregnancy group started meeting on April 27, 2005, and will meet through the end of November when the women are all due to deliver. The group is comprised of nine women, all of whom are Spanish-speaking. A Health Department interpreter is present at all sessions to interpret the conversations and information shared between the CenteringPregnancy Program staff and the clients. A bus from the Prince George's County government's Call-A-Bus service picks up the women from a centralized point near their homes and transports them to and from the clinic location where the sessions are being held. The bus ride itself serves as an additional opportunity for clients to bond with each other and for staff to educate them about the services they will receive through the CenteringPregnancy Program.

Although the first Centering group is currently only halfway through the program, the participants are already reporting tremendous satisfaction with the care they are receiving and are forming close relationships with each other. The staff are equally pleased with the progress participants are making towards becoming actively involved in their care and empowered to take greater responsibility for their own health. Given the positive feedback the CenteringPregnancy Program has received in these early stages, the Health Department is recruiting 16 clients for a second group that will meet from September 2005 to May 2006. In the meantime, the Health Department looks forward to "graduating" its first Centering class at the end of the year and reporting on the birth of nine healthy babies.

## Black Babies S.M.I.L.E. Expands

*Nia M.J. Williams RN BSN MPH*

The African American Health Program of Montgomery County, Maryland is proud to share with you information on its Black Babies S.M.I.L.E (Start More Infants Living Equally Healthy) program.

This program was developed by the Montgomery County Department of Health and Human Services in 1997. The implementation of this program was in response to the high incidence of infant mortality among blacks in Montgomery County. The main goal of the program is to lower this infant mortality through the nurse case management, home visitation program. Currently, there are two staff nurses who carry a case load of 50 women and 30 infants each.

To qualify for this free program, women must be African American or of African decent, and live in Montgomery County, Maryland. They are visited by the nurses at any stage in pregnancy or in the postpartum phase, and followed in the home once a month or as needed until their infant turns one year of age.

The visits focus on the prenatal health of the client, what is normal in pregnancy and what is abnormal, as well as encourage the client to be compliant with the Physician's orders. The program also provides referrals to various social services within the community and provides ongoing health education and support to ensure a healthy pregnancy and birth. Lactation support is provided through a (free of charge) breast pump loan program. Motherhood and infant health and development are actively supported until the infant turns one year of age.

To be able to S.M.I.L.E. even more, the African American Health Program will be adding a third nurse case manager to the program, as we plan to increase the number of women and infants served in Montgomery County.

Referrals can come to our office from any source as long as the women meet the criteria mentioned above. We also accept self referrals into our program. This program is NOT a replacement for pre-natal care, but a compliment to the care already being provided by the OB/GYN.

To make a referral or find out more about the program, please call 240-777-1833.



# Delivering Effective Asthma Management Interventions for Latino Populations

*Sonia Mora, Manager, Latino Health Initiative and Paola C. Fermam-Zegarra, Program Coordinator, Cancer Program, Latino Health Initiative*

Asthma is a serious public health problem. Asthma affects both adults and children, and it is the most common chronic disease of childhood affecting 12.7 percent of all children in the U.S. According to the Asthma in Maryland 2003 report, in children, asthma exacerbations may result in missed school days due to illness, medical appointments, and hospitalization. Although asthma affects all types of children, low-income and racial/ethnic minority children, including Latinos, experience substantially higher rates of fatalities, hospital admissions, and emergency room visits due to asthma (Healthy People, 2010.)

In February 2005, the Latino Health Initiative (LHI) of the Montgomery County Department of Health and Human Services established an Asthma Management Pilot Project, through a grant provided by the Center for Maternal and Child Health of the Maryland Department of Health and Hygiene.

The Latino Asthma Pilot Project was designed to increase understanding of asthma management by low-income Latino parents of children with asthma, and to develop and test culturally and linguistically appropriate interventions among this group. The pilot project also seeks to understand asthma-related issues that are particular to Latinos in terms of their knowledge, attitudes, perceptions, and practices. The desired outcome is Latino families who are empowered to appropriately self-manage asthma in their children.

During FY06, the LHI will conduct 12 two-hour long Spanish-speaking educational group sessions for parents of children with asthma, using an asthma education curriculum. Educational sessions will be conducted at a time and place convenient for program participants. Children with asthma will actively participate in activities during these sessions. Additionally, culturally competent Spanish-speaking coaches will offer support and follow-up to program participants through weekly interventions to identify possible problems and support families in overcoming these problems, through referral to appropriate services and encouragement.

For more information on the Latino Asthma Project, please contact the Latino Health Initiative at (240) 777-3221.



## Prince George's County Projects Highlighted

*Katina Washington, Administrative Aide I, Healthy Teens, Kevin West, Program Staff, Adams House, Prince George's County*

### Adam's House—A Place for Men

Adam's House of Prince George's County Health Department, Division of Maternal and Child Health serves as a center for men providing health care, social support, parenting groups, child support enforcement assistance, job preparation and male family planning. Adam's House marks a new beginning in the lives of men in Prince George's County who are in need of support, guidance and assistance in managing their lives and connecting with their children and families. As an integrated and comprehensive center, Adam's House is a provider of direct service and a clearinghouse link to outside resources. The goal of Adam's House is to promote healthy manhood, personal growth and the importance of loving fathers in the social, emotional, spiritual, and moral development of children.



Among other services and programs offered at Adam's House is a health clinic for uninsured males, ages 11-35. A medical doctor and a registered nurse encourage healthy habits for both physical and sexual health, and provide all health

assessments, including physical exams for sports activities and employment verification, sexually transmitted infection (STI) and HIV testing and counseling. As a part of the sports fitness exams, young males are encouraged to adopt a healthy lifestyle of practicing abstinence and living substance-free to enhance their quality of life.

In conjunction with the outreach programs available at Adam's House, there is an established relationship with the Prince George's County Courts. A representative from the office attends Child Support Courts twice a week to act as a liaison and the courts refer county males to participate in the services that are offered at Adam's House. Men that utilize these services find it both beneficial and rewarding. Services include job preparation and placement, commercial driver's license (CDL) written examination training, and assistance with driver's license reinstatement. Adam's House also has established relationships with Parole and Probation. Many of the men from Parole and Probation have attended the weekly group sessions as part of their rehabilitation process.

Adam's House offers a weekly group counseling session as part of the Male Involvement Program, and men who are residents of Prince George's County are welcome to attend the "Life Skills Development Group." This group is designed to address life issues which men might not normally discuss. Some of the topics include: Communication Skills, Male/Female Parenting, Anger Management, Spirituality, Marriage and Family.

### Healthy Teens Center—The Clinic For You

In the mid 1980s, Maryland faced a high teen pregnancy rate. To combat this problem, the Department of Health and Mental Hygiene launched a teen pregnancy prevention program. To support this program, Prince George's County received the Healthy Teens and Young Adults grant, which created the Healthy Teens Center in Landover, Maryland.

Healthy Teens is part of the Prince George's County Health Department's Division of Maternal and Child Health and has been operating for the past 15 years serving females, ages 10-19. Located in a small strip mall that attracts teens, the center is primarily focused on clinical services for reproductive wellness as well as education and behavior modification.



The services that Healthy Teens provides are reproductive exams, sexually transmitted infection testing and treatment, birth control, HIV testing, education and counseling. Wellness has become a big part of the services offered, stressing nutrition and exercising. The clients receive care administered by Certified Nurse Midwives, Registered Nurses and Medical Social Workers. The staff uses examination and education to stress the importance of total reproductive wellness. With the decline in teen pregnancy and the rise in sexually transmitted infections, Healthy Teens is in the process of modifying its services to include more social and educational support.

This fall, Healthy Teens will be starting a support group for clients in the community that will help promote positive behavior and reduce negative socialization contributing to risky behavior that can lead to unwanted pregnancies and sexually transmitted infections. Some topics that will be discussed are Reproductive and Emotional Health, Communication, Self Esteem and Self Image, and Career and Financial Planning. The goal of the group is to prepare our young women for adulthood and eventual parenthood.

## March of Dimes Advocates for Continued Expansion of Newborn Screening Programs

The previous issue of Perinatal Network included an article on Reproductive Genetic Testing. In the article, Newborn Screening (NBS) was cited as a means for early identification of infants who are affected by certain genetic, metabolic, or infectious conditions for which early diagnosis and treatment are available.

In June 2005, the March of Dimes issued a state-by-state report card on newborn screening. Expanded newborn screening is now required by law in dozens of states, but most infants are still not covered by the full panel of 29 tests recommended by experts. Only Mississippi, which is home to just about one percent of babies born in the US each year, currently provides screening for all 29 recommended conditions. Only eight states are screening for cystic fibrosis (CF), despite the fact that CF is one of the most common genetic diseases in America.

The March of Dimes recommends that every baby born in the United States receive screening for a uniform panel of 29 disorders that includes metabolic conditions and hearing deficiency. All of these disorders can be managed or treated to prevent severe consequences, if diagnosed early. The extent of newborn screening for serious and treatable disorders depends entirely on the state in which a baby is born. For infants affected with these conditions, the tests can mean the difference between life and death, or health and lifelong disability.

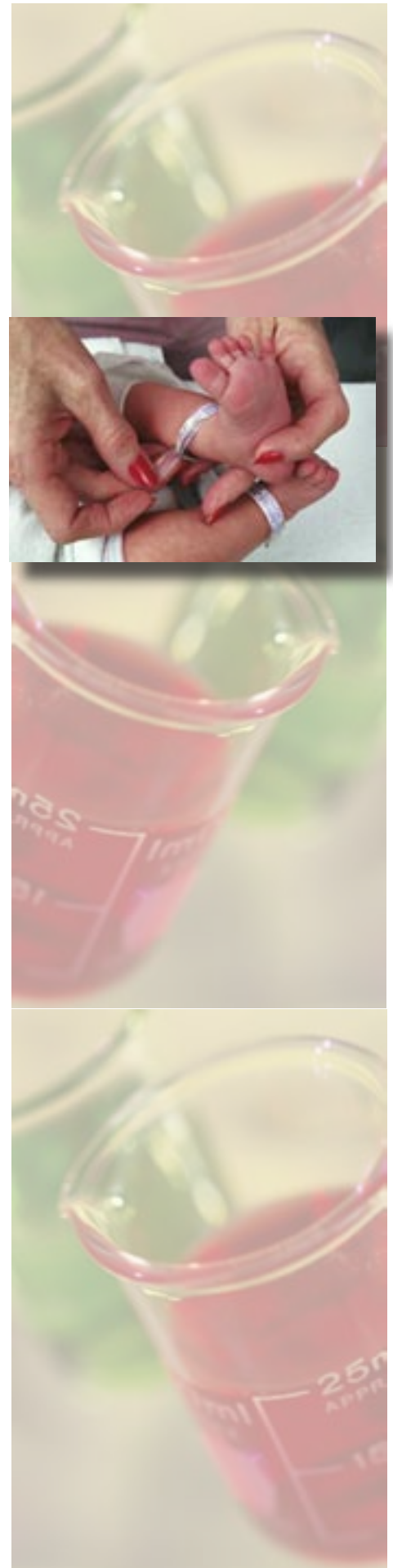
According to the report, 23 states have expanded their newborn screening programs to include more than 20 of the 29 disorders recommended in the 2005 report by the American College of Medical Genetics—accounting for about 38 percent of approximately four million babies born each year in the US. Twelve states—which account for about 20 percent of babies—require screening for between 10 and 20 disorders. Another 15 states, plus the District of Columbia—involving about 43 percent of babies—currently screen for fewer than 10 conditions.

The State of Maryland has made and continues to make tremendous progress with newborn screening. The state officially conducts 27 screening tests. Of the remaining two, one test is actually being performed and reported only if the results are abnormal. The State Advisory Council on Hereditary and Congenital Disorders voted to recommend that Maryland implement screening for cystic fibrosis. It is expected that this test will be part of the state's newborn screening program by early 2006.

Newborn screening is a simple, safe and efficient way to identify and quickly treat babies with a potentially devastating problem. The testing is performed on just a few drops of blood, usually from a newborn's heel, collected before hospital discharge. If the result is positive, the infant is re-tested and given treatment as soon as possible, before becoming seriously ill from the disease. In states where testing is limited, parents can arrange for additional tests, but these can often come at additional expense.

The March of Dimes advocates for continued expansion of newborn screening programs so that all babies across America will receive the benefits of testing for all of the 29 core conditions. A new brochure entitled, "Newborn Screening," containing a list of the 29 disorders and other important information, can be ordered from March of Dimes and the list of tests currently provided by each state is available at [www.marchofdimes.com/nbs](http://www.marchofdimes.com/nbs). The March of Dimes is a national voluntary health agency whose mission is to improve the health of babies by preventing birth defects, premature birth and infant mortality.

For more information, contact Dr. Miriam G. Blitzer, volunteer spokesperson for the March of Dimes Maryland Chapter, and Professor and Head of the Division of Genetics, Department of Pediatrics, University of Maryland School of Medicine, at 410-706-7590 (via Becky Ceraul, Public Relations) or the March of Dimes Maryland Chapter at 410-752-7990 or [www.marchofdimes.com/maryland](http://www.marchofdimes.com/maryland).





# MedChi Launches Center for a Healthy Maryland

Meena Abraham, MPH

MedChi, The Maryland State Medical Society has launched the Center for a Healthy Maryland, drawing together its public health and community service programs in order to underscore and reinforce the medical society's commitment to health leadership for Maryland.

Formerly known as the MedChi Foundation, the Center for a Healthy Maryland is a tax-exempt, charitable affiliate of MedChi that administers the medical society's educational, charitable and public health programs. The Center's primary activities are in the areas of health promotion, with programs directed at the public to improve health status, and quality improvement, and with programs aimed at clinicians to help them better serve the health care consumer.

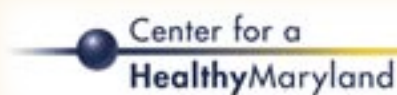
Existing programs range from training and study of maternal and child health issues, to cancer control, to substance abuse and mental health, and are funded principally by grants and contracts with external partners, rather than member dues. The Center will build on this experience with particular emphasis on forming partnerships with other leaders in business, education, the faith community and community groups to advance the concept that health leadership will yield improved health status and quality of care.

"We are committed to the idea that physicians have a special role to play as health leaders in our communities, but we can't do it alone," said Allan D. Jensen, M.D., Chair of the Center's Board of Trustees. "Improving health status and quality will take a sustained leadership commitment that runs across all the main sectors of society, especially as we extend our reach into health promotion."

Maternal and child health status is a fundamental marker of public health. MedChi has managed or consulted in a number of programs in this area, including the Maryland Maternal Mortality Review, the Maryland Health Care Coalition Against Domestic Violence, the Maternal Depression Project, and the Prevention of Alcohol Use During Pregnancy Project (FASD Prevention) in collaboration with Baltimore City Healthy Start. Other projects affecting health status include the Coalition for Skin Cancer Prevention in Maryland and Smoke-Free Maryland, the state's leading anti-tobacco initiative.

Developing initiatives to address improvements in health disparities, patient safety and quality of care, especially in the outpatient arena, will be an important component of the Center's future efforts. It is expected that these will include projects aimed at improving communications between physicians and patients, inconsistency in quality of care, and system breakdowns in key areas, like prescriptions.

For more information about the Center's activities, visit [www.healthymaryland.org](http://www.healthymaryland.org) or contact Meena Abraham, MPH, Executive Director, at [mabraham@medchi.org](mailto:mabraham@medchi.org) or 410-539-0872.



## National Institute of Mental Health Studies the Role of Hormones in Postpartum Depression

Each year postpartum depression (PPD), a common and serious condition, affects millions of women worldwide, occurring in approximately 10 percent after childbirth. Symptoms include sadness, anxiety, trouble sleeping, tearfulness, hopelessness, fear of hurting the baby, an inability to enjoy anything and rarely, in its most severe form, psychosis. Recent studies suggest a role for hormones in precipitating depression. Following delivery, the levels of both estrogen and progesterone drop dramatically, and some researchers believe that the precipitous change in these hormones may be responsible for depression in a subgroup of women.

What is it that makes some women vulnerable to depression in relation to these hormonal changes related to childbirth? If changes in hormone levels after delivery contribute, would supplementing these hormones during the postpartum period help relieve the depression? The answers to both of these questions currently remain unanswered; however, there is evidence that postpartum depression may have a genetic component, particularly in its most severe form (postpartum psychosis.) Identifying genes that might contribute to a vulnerability to developing PPD might be helpful, not only in identifying women at risk but potentially for targeting effective treatments for this disorder.

The National Institute of Mental Health in Bethesda, Maryland, is currently conducting several studies, including assessment of the antidepressant efficacy of estradiol, the role of genetic factors in the vulnerability to experience PPD, and the role of hormone levels or changes in hormone levels as a trigger for PPD. Anyone interested in learning more about these studies should contact Linda Simpson St. Clair M.S.N. at 301-496-9576.

# Initiation of the Eastern Shore Oral Health Action Network (ESOHAN)

*Jennifer Istre Walker, M.P.H.,  
Coordinator, Oral Health Program,  
Wicomico County Health Dept.*

In March 2005, the Wicomico County Health Department was awarded a planning grant to initiate the Eastern Shore Oral Health Action Network (ESOHAN.) The primary goal of ESOHAN is to establish a formal network charged with developing a strategic plan that addresses disparities in access to, and utilization of, oral health care services affecting children and low-income families.

The one-year grant, funded by the Office of Rural Health Policy in the federal Health Resources and Services Administration (HRSA), focuses on oral health planning for a three county region (Wicomico, Caroline and Dorchester). The Network has expanded to include representatives of local health departments from the six counties comprising the mid and lower shore, the Eastern Shore Area Health Education Center, University of Maryland Dental School, DHMH Office of Oral Health, regional hospitals, and other governmental and private organizations.

The network planning process has resulted in the development of a service delivery consortium targeting oral health access issues, particularly in Dorchester County. Last month, members of the Children's Regional Oral Health Consortium (CROC) submitted a three-year Rural Health Outreach Grant proposal to HRSA's Office of Rural Health Policy. The consortium includes the Eastern Shore Area Health Education Center (AHEC); UMD Dental School; two federally qualified community health centers, Choptank Community Health System, Inc. and Three Lower Counties, Inc.; and a local hospital, Shore Health System, Inc. CROC's work plan focuses on low-income children who are uninsured or enrolled in Medical Assistance (MA.)

There are three components to the proposed program: 1) the development

of a comprehensive dental center in Dorchester County (no dental providers in this county accept Medicaid); 2) the development of a regional hospital-based pediatric dental program serving the six mid and lower shore counties; and 3) the development of community-based clinical and educational training opportunities for dental hygiene students on the entire Eastern Shore.

The ESOHAN work plan is based on realistic expectations that existing working models can be studied

a decline in dental caries, children in Maryland still have significant dental disease. Children living on the Eastern Shore exhibit more dental disease than any other area of the state. (See Table I.) In addition to oral disease issues, the Maryland Survey showed that school-age children on the Eastern Shore were the least likely in the state to have seen a dentist within the past year.

The survey results indicate that low-income children, those eligible for free/reduced lunch, had 52 percent

Table I

Dental Health Issues in Children (2000)	Eastern Shore	Maryland	United States
Dental Visits within the Past Year	63.7%	70.2%	74.1%
Untreated Dental Decay, School Children	53.7%	41.6%	23.1%
Untreated Dental Decay, K and 3rd Grade	72%	52.6%	29%
Dental Sealants, 3rd Grade	13.9%	23.7%	23%

and translated into an expansion of community-based oral health delivery programs. The Eastern Shore Dental Society is a critical partner in efforts to develop a model of care that increases access to diagnostic and restorative services, particularly in underserved populations. The network is also exploring methods of raising community awareness of oral health issues. This network will ultimately foster dissemination, replication and adaptation of proven, innovative community-driven solutions that have already made inroads to improved oral health care access for children.

The need for improved oral health services on the Eastern Shore is compelling. The majority of the Eastern Shore is recognized as a Dental Health Professional Shortage Area by HRSA. In 2001, the University of Maryland's (UMD) Department of Pediatric Dentistry and the Maryland Department of Health and Mental Hygiene's (DHMH) Office of Oral Health, conducted a comprehensive, statewide survey of the oral health status of school-aged children in Maryland. The results indicate that, notwithstanding a trend towards

more untreated dental caries than children eligible for free lunch. Uninsured children are 2.5 times less likely to receive dental care.

Oral health in this region is complicated by the inconsistent availability of fluoridated water. Nearly two-thirds of the U.S. has access to this preventive oral health method. However, in the six counties currently engaged in ESOHAN oral health planning, only 36 percent of the population has access to fluoridated water.

In a pilot of the school-based dental program in Caroline County conducted by the Choptank Community Health System (CCHS), 80 percent of all dental disease was found in 20 percent of the poorest children, and one in five children attend school each day with dental pain. A review of data from dental screenings conducted at mid and lower Shore Head Start Centers in 2004-05 showed that over one third of the 777 three to five year olds screened had dental decay. Wicomico County school screening data from 2003-2004 found that 47 percent of the 602 elementary children screened had decay by visual exam.

For source information contact Jennifer Walker at [jlwalker@dhmh.state.md.us](mailto:jlwalker@dhmh.state.md.us)

# Baltimore is Working to Save Babies One “Onesie” at a Time

*Karen Angelici, MPP, Bureau Chief for Maternal & Infant Care*

The Baltimore City Health Department is reaching new parents throughout the city quickly and inexpensively with life-saving infant safe sleep messages printed on delightful baby t-shirts, often referred to as “onesies.” The onesie, shown below, is an essential component of the City’s ABC’s of Safe Sleep Initiative, launched late last year.

The Health Department hopes that the babies in Baltimore will benefit from the Initiative, where the deaths of 18 infants in 2004 involved bedsharing or other unsafe sleep situations with a parent or family member, making unsafe sleep environments (and associated suffocation) the second leading cause of infant death in the City. The ABC’s of Safe Sleep Initiative seeks to help parents protect their babies from the risk of suffocation associated with bedsharing, soft bedding and sleep surfaces, and also from the risk of SIDS, which has been linked to prone sleep positioning.

The ABC’s of Safe Sleep Initiative onesie and printed insert educate new parents on the safest way for a baby to sleep... Alone, on his/her Back, in his/her Crib. Staff from the City’s state-funded home visiting program, which provides intensive case management services to high-risk, low-income families throughout the City, are using these innovative educational tools to help reinforce safe sleep messages as they counsel clients. The Department has also created a crib fund to accept tax-deductible donations from foundations, public and private organizations, and individuals. Funds are used to purchase cribs for families in need.

To date, the Initiative has received support from several key agencies and organizations, including DHMH, the Baltimore Ravens, the Baltimore Orioles, the Abell Foundation, the C.J.SIDS Foundation, the Safe and Sound Campaign and others.

In partnership with a national infant survival organization, First Candle/SIDS Alliance (the leading partner of the NIH-funded “Back to Sleep Campaign”) the Health Department has now launched a Web site to make onesies packaged with the educational inserts available to everyone at a reasonable cost. A small portion of the purchase price will be donated to First Candle to help babies survive and thrive, and to purchase cribs for Baltimore families who cannot otherwise afford one.

To place an order, go to [www.firstcandle.org](http://www.firstcandle.org), or call First Candle at 1-800-221-7437. For more details or a free sample, contact Karen Angelici, MPP, Bureau Chief for Maternal and Infant Care at the Baltimore City Health Department, by Email: [karen.angelici@baltimorecity.gov](mailto:karen.angelici@baltimorecity.gov), or by telephone: 410-396-3769.



## First Candle/SIDS Alliance

First Candle/SIDS Alliance exists to promote infant health and survival during the prenatal period through two years of age. We do this through programs of advocacy, education and research. SIDS and Other Infant Death bereavement services are a critical component of our mission.

[www.firstcandle.org](http://www.firstcandle.org)

## Cribs for Kids

'Cribs for Kids'® is a safe-sleep education program for low-income moms to help reduce the risk of injury and death of infants due to unsafe sleep environments. 'Cribs for Kids'® Programs throughout the country provide a Graco Pack N Play® Crib and educational materials regarding 'safe sleeping' and tips to protect your baby.

[www.cribsforkids.org](http://www.cribsforkids.org)





## Merging Clinics in the Howard County Health Department

*By Sheila Palmiotto, CHN II, HCHD Maternity Program*

In a continuing effort to provide comprehensive health care for gravid uninsured women of Howard County, and in light of the association between pre-term labor and gingival infection, the maternity and dental clinics of the Howard County Health Department have successfully joined together to provide services to this target population.

Periodically, while waiting to be seen by the midwife on clinic day, the maternity patients and their children get to see presentations made by the department's dental hygienists on such topics as: preventive dental care, Bottle Mouth Syndrome, the importance of oral hygiene during pregnancy and the appropriateness of oral care for infants and toddlers. Toothbrushes and dental floss are provided to the maternity patients and their children with instructions for proper use. Appointments are made for dental screenings and treatments.

Conducting these dental presentations during the clinic waiting time also provides a perfect opportunity to address this predominantly limited English proficiency (LEP) population while interpreters are present for clinic appointments. Handouts on the dental clinic hours, the dental services available, and how to access these services are distributed in both English and Spanish. Together we are making a difference.



## Child Fatalities: A Workshop Series for First Responders Evaluation

*Carol King R.N.C, B.S.N., Cecil County Health Department, Division of Health Promotion*

The Perinatal Child/Death Community Action Team (CAT) at the behest of the Cecil County Child Fatality Review Board (CFR) implemented "Child Fatalities: A Workshop Series for First Responders" with three workshops entitled "Response/Investigations," "Supporting the Family" and "Secondary Trauma: Impact On Responders." The purpose of the workshop series was to address the needs of the law enforcement and medical communities when responding to an unexpected child or infant death.

These needs include: identifying role and responsibilities for the law enforcement and medical professionals to conduct a thorough investigation, providing support for family and friends who have suffered a child or infant loss, and addressing secondary trauma suffered by first responding professionals. These workshops were funded by an Improved Pregnancy Outcome Grant and sponsored by Cecil Partnerships for Children, Youth and Families in partnership with the following organizations and committees: Cecil County Department of Social Services, Cecil County Perinatal/Child Death Community Action Team, Upper Bay Counseling and Support Services, Maryland State Police Barrack F, Cecil County Sheriff's Office, Cecil County Child Advocacy Center, Union Hospital of Cecil County, Cecil County State's Attorney's Office, Cecil County Health Department, Cecil County Public Schools, North East Police Department and Perry Point VA Medical Center.

Professionals involved in responding to unexpected child and infant deaths invited to these workshops included: law enforcement, emergency medical technicians, social workers, nurses, counselors, bereavement specialists, and school personnel.



# Calendar Events

## November

14

**March of Dimes Celebrate Chefs.**  
Culinary Extravaganza and fundraiser. For more information visit [www.marchofdimes.com/maryland/](http://www.marchofdimes.com/maryland/)

15

**March of Dimes National Prematurity Awareness Day**

29

**Second Annual March of Dimes Prematurity Summit Reducing Racial Disparities In Birth Outcomes.**  
Featured Speaker: Michael C. Lu, MD, MS, MPH. Greenbelt Marriott Hotel  
5:00–8:30 p.m. Invitation-only.  
For more information contact: Anne V. Eder, 410-752-8073 or [aeder@marchofdimes.com](mailto:aeder@marchofdimes.com)

## January

**Intensive STD Training for Clinicians**  
The Perinatal Infections Outreach Program's intensive training course will be conducted by the Region III STD/HIV Prevention Training Center. Faculty for the training course are from Johns Hopkins University's School of Medicine. Both CMEs and CEUs are provided.

The target audience includes physicians, nurse midwives, nurse practitioners and physician assistants working in STD, Family Planning, School Health, HIV, and other Primary Care settings both public and private. The training is designed as an update and refresher for experienced clinicians as well as providing comprehensive instruction for those who are less experienced.

Held on consecutive Fridays in January the training will entail three days of lectures in the conference room, one day of clinical practicum at an STD clinic in Baltimore City, and several hours working with live model teaching associates in a clinic setting.

There is limited capacity for the practicum portions of the training, so in order to ensure your participation, the earlier you respond, the better. Attending just the

three days of didactic training is also an option.

Contact Elisabeth Liebow, Coord., Perinatal Infections Outreach Program, Baltimore County Department of Health. 410-887-3134, fax: 410-377-5397

Email: [eliebow@co.ba.md.us](mailto:eliebow@co.ba.md.us)

Please send all calendar submissions to the editor well in advance in order to get your event published in time.

Send submissions to: [perinatalnetwork@livingmind.com](mailto:perinatalnetwork@livingmind.com)